

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
Requestor's Name and Address Trinity Medical Solutions 9901 Brodie Lane, Ste. 160 PMB #204 Austin, TX 78748	MDR Tracking No.: M4-04-0266-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Co. BOX #: 54	Date of Injury:
	Employer's Name: Brown Karhan Private Group Rehab., LLP
	Insurance Carrier's No.: 99D-330980

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/05/03	03/05/03	E1399	\$95.00	\$95.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in part... "Trinity Medical Solutions has the burden to prove "fair and reasonable" reimbursement. Trinity Medical Solutions' burden of proof is based on two solid foundational facts: Section 1: Texas Mutual Insurance's reduced reimbursement is not "fair and reasonable" because their actual reimbursement is the Maximum Allowable Reimbursement (MAR) for another "treatment and/or service". Section 2: Trinity Medical Solutions' billed amount for the Impulse HVG is "fair and reasonable" based on current methodology guidelines established within the TWCC Fee Guidelines structured within the Medicare Payment Policies.

Requestor has also included redacted EOBS.

PART IV: RESPONDENT'S POSITION SUMMARY

No position statement submitted.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per rule 133.304 (i)(1-4), the insurance carrier did not provide a methodology to support the amount reimbursed is fair and reasonable. Furthermore, Per Rule 133.307 (g)(3)(D), the requestor has submitted documentation that demonstrates and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due				
3/5/2003	E1399	\$95.00	\$95.00				
Total Left Column:			\$95.00				
Total Amount Due:			\$95.00				

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$95.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Benita Diaz

May 19, 2005

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite #100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____